June 20, 2005

Testimony of Richard Garfield

To the Subcommittee on National Security, Emerging Threats, and International Relations

On the Efficiency and Effectiveness of the Development Fund for Iraq in the Health Sector

Dear Members of Congress and other Interested Parties,

Background and Expertise

My name is Richard Garfield. I am a Professor of Nursing and Coordinator of a World Health Organization Collaborating Center at Columbia University, and a Visiting Professor at London School of Hygiene and Tropical Medicine.

I work in countries with wars or economic sanctions to assess humanitarian conditions. This has sometimes thrust me into political situations, but I am an epidemiologist and nurse, not political scientist. There are few developing countries for which we have a clear, real-time picture of who is at risk and how to reduce that risk during crises. I mainly work with national authorities to improve their ability to manage the crisis, improving data collection and its use to make scarce resources go further

I have done this in Cuba, Haiti, Yugoslavia, Afghanistan and Liberia for national governments and UN organizations over the last two decades. It was in this context that I first visited Iraq in 1996. Since then I have visited Iraq almost every year to assist UNICEF, the World Food Program, and the Iraqi Ministry of Health. I evaluated the quality of mortality studies and created independent estimates of mortality changes, evaluated the overall humanitarian impact of the Oil for Food program, participated in research on income and living standards in northern Iraq, and carried out an analysis of nutritional status during the 1990s.

After the 2003 invasion, I assisted the World Health Organization, UNICEF, and the American NGO International Medical Corps to assist in reconstruction, manage reactivation of health services, and prepare the post-Oil for Food UN program. He collaborated with the CPA and the Ministry of Health to reactivate the health system throughout the post-war summer, authored the post-war 'Watching Brief' on Health of the World Bank in the summer of 2003, designed a child survival strategy for USAID in Iraq in early 2004, and participated in research to identify changes in mortality since the 2003 invasion. During my most recent visit to Iraq, I assisted the Ministry of Health to

redesign health worker training and human resource development in January of this year. I am also a member of the Humanitarian Assessment group of the Independent Inquiry Committee into the UN Oil for Food Programme which is soon to conclude an assessment of the effectiveness and efficiency of the Oil for Food Program in alleviating the country's humanitarian crisis during 1997 - 2003.

I met most of the people working for the CPA in the health sector and observed their activities and priorities. I had to deal with them in some manner as an on-the-ground consultant for the World Health Organization, and as one of two authors of the main analysis of the health system at that time, the 'Watching Brief' prepared by UNICEF, the World Bank, and WHO. I thus an in a position to comment on the efficiency and effectiveness of the CPA's work in health, but not specifically about their budgeting or spending of DFI funds as it was never clear what activities were based on these funds.

Composition of the CPA Health Team

There were serious deficits in the composition of the team. Perhaps most importantly, the team did not begin to arrive in Iraq until 9 weeks after Baghdad fell to the Coalition. The vacuum of leadership that occurred during those 9 weeks greatly weakened the initiative of the reconstruction effort. We learned of the appointment of Mr. James Haveman to the post of Senior Health Advisor to the Ministry of Health from an article in the New York Times. No one at the Ministry of Health and no one among the informal military medical leadership group at the palace were able to confirm if this appointment was indeed valid, and as weeks passed without any forward movement the general view was that the appointment would not occur. We truly were surprised when after more than two months, Mr. Haveman appeared with a team in Baghdad.

Among members of that team, there was not a single individual with an advanced degree in public health. I think not one member of that team, including Mr. Haveman, had ever lived outside the United States. This lack of experience and expertise was another blow to the widespread desire among Iraqis to fix the health system and improve the health of the population.

CPA Work in Health

Aspects of Mr. Haveman's leadership style represented a further blow to that effort. Mr. Haveman saw to it that the only other US citizens in Iraq in an official capacity were dismissed from their posts. This included Jack Thomas of US AID, and Mary Patterson of the firm ABT Associates, the main US AID health subcontractor. These individuals each had many years of international health project management experience in the Middle East and elsewhere and could have been key in developing efficient and effective program priorities and administration. Instead, Mr. Haveman had the support and advise mainly of clinicians from the DoD, none of whom had run or built health systems. Inevitably, the work of the CPA would then focus on running hospitals and providing medicines. While these activities are essential, they would have less impact on improving the health of the Iraqi people at that time than a focus on community health

education, outreach for basic health promotion programs, and the elaboration of financial management, systems planning, and pharmaceutical administration systems appropriate to a middle income developing country. The failure to focus on these issues mirrored the major problems of the Oil for Food program over the prior 8 years, where commodities were delivered but training, maintenance, and management of the health system had deteriorated enormously. The aspiration of making the health system appropriate to the health conditions of Iraq could not be achieved by the CPA team.

The mystery surrounding CPA functioning did not end when the team arrived. Little of their work appeared to result from consultation with Iraqis, and few announcements of heir decisions ever appeared, even within the Ministry of Health. Although the team did take up posts in the Ministry of Health building, there was virtually no use of mass media, then growing rapidly to either share decisions with the public or to reach the public for health promotion. Not only was a great opportunity lost, but most people in Iraq were left in the dark about the interests and actions of the US in health. More of their publicity was oriented toward to US than toward Iraqis.

One area where this would have been important was with regards to user fees at ambulatory clinics. Such a system had been setup four years before the fall of the Hussein regime. These user fees paid supplements to physicians that kept them at work and provided for the purchase of cleaning supplies, bandages, oxygen, and other essential local goods. The normal way to examine this situation would have been to identify the role of these fees in unit budgets, identify alternative sources of funds, and determine who didn't use health services because of these fees. Instead, and without consultation with knowledgeable Iraqis, Col. Garner simply abolished the fees, throwing clinics into disarray as great as the recent looting. Doctors didn't come to work without the accustomed salary supplements and a crisis in oxygen supply resulted. CPA was forced to quietly withdraw the abolition of user fees, only to find them attacked and prohibited, and then reestablished, under subsequent Iraq administrations. CPA should have provided the example of well informed studies leading to policy analysis on user fees; instead Iraqis continue to consider this strictly a political matter. Lacking expertise, under CPA, indeed, it did remain a political issue alone.

The private sector in health had grown a great deal during the years of sanctions. It was not integrated into the public medical care system, nor was coordination with it developed. Both of these would have required a higher level of policy expertise than existed among the CPA.

One o the biggest issue for CPA in health was 'corruption'. The term was never defined, and Iraqis had a very different understanding of what is and was corrupt than the American did. Anti-corruption efforts were highly moralistic rather than administrative. They provided little to improve the management and oversight in a period when supervision of work declined and punishments for not obeying orders disappeared. In this context, the robbery of medicines and other goods in the health system flourished. The first-post CPA Iraqi Minister of Health believed that he largely rooted out corruption in

the medicine supply system, while people in the system say it is far more corrupt than under Saddam.

More important, but virtually unaddressed, was the mis-utilization of medicines. It appears that the majority of antibiotics, for example, are given to patients whose condition does not warrant the use of antibiotics. Use of antibiotics per capita in Iraq is higher than in the US. The solution to this problem would have involved training and retraining, supervision, and monitoring. Since steps weren't made in this direction, the system still hemorrhages a massive amount of the goods for health at a time when the people can least afford to be without medicines. The elaboration and distribution of treatment algorithms, chart reviews, and in-service education seminars could have greatly improved training of health workers, but it never occurred. The value of medicines lost this way far outweighs the amount lost to corruption, either before or after the 2001 invasion.

Lacking planning and management skills, the CPA led staff at the Ministry of Health in 'visioning' exercise. Even during my visit in January of 2005, senior staff described the vision of an affordable, equitable system, but hadn't begun to develop skill in basic planning tools. Our Iraqi counterparts need and deserve to learn these skills and we Americans have more of these skills than anyone.

CPA frequently described the 'bad old days' under Saddam and described the present with an 'everything-is-coming-up-roses tone. Critical analysis did not go on and CPA staff misunderstood the limited data generated by the health system. Little attention was devoted to improving the collection and analysis of health services data, though this should have been among the CPAs first tasks.

In the context of this limited skill and focus, it was inevitable that both the utilization and the documentation of the use of DFI funds would be inadequate. Even the request from the CPA for $900 million for the health sector, as part of the $18.6 supplemental appropriations for Iraq, arrived in Congress in a shocking form. The document was a total of 8 pages, full of typos, repetitive paragraphs, and partial sentences. No justification was provided in that document for the funding amounts requested. At that time I thought, 'If one can't make a reasonable request for funds, one certainly will not monitor or report on their use adequately.' This is exactly what seems to have occurred.

TO their credit, the CPA team remained engaged in Iraq and highly dedicated to their work throughout their tenure. CPA set as a main health goal the halving in one (and then two) years of the Infant Mortality Rate (IMR). Yet they never knew what the IMR was, and never established plans to measure it! It could have been a centerpiece of the work of the health system, but instead became merely a rhetorical goal. CPA used a survey that had been carried out 4 years earlier, using data 6.5 years earlier, as their assumed current IMR. Anyone with minimal skills in demography knows that this was an invalid indicator of the current rate. Even worse, they never put in place a plan to monitor mortality rates to see how well the country was achieving their main goal. CPA never overcame its own rhetoric to get passed 'happy stories' for US consumption to identify valid health

monitoring methods. We have no reason today to believe that the IMR is any lower than it was when the invasion occurred.

Health Conditions Today

The only major effort to assess living conditions since UNICEF's MICS survey in 2000 was carried out last year under contract to the UNDP. The Norwegian Statistical Agency carried out a large scale representative sample survey to assess living conditions in Iraq in spring and summer of 2004

The survey showed that most people do now have access to health services provided by the Government, and most of those services are better stocked and staffed than they were before 2003. The quality and effectiveness of services are not very good, however. Popular dissatisfaction is common (38%). Most children going to a clinic with diarrhea are given antibiotics (68%) rather than the oral dehydration fluids (37%) they should receive. While 98% of births are attended by a nurse, doctor, or midwife, death due to childbirth continues to be quite high (193 per 100,000 live births).

10% of households are overcrowded. 6% of homes have been damaged by wars. Only 60% have regular access to clean water (down from 90% in 1989). The percentage of the population with piped connections for waste water disposal increased in the early 1990s, but the proportion with treatment of that water was small in the beginning of the period and approached zero by 1996. Little recovery occurred through 2003, and this improvement was largely lost through looting and the loss of electricity generating capacity in the months following the 2003 war. In the 2004 survey sewage was observed in the street near 39% of all houses.

Malnutrition among children under five years of age has declined from the very high rates observed in 1996, but shows much less recovery since 2000 and remains much higher than it was early in the crisis, in 1991.

	1991	1996	2000	2004
Acute Malnutrition	3.0	11.0	7.8	7.5
Underweight	9.0	23.4	19.5	11.7
Chronic Malnutrition	18.7	32.0	30.0	22.7

Deaths due to the war in recent years were estimated at 18,000-29,000. This represents about 56 deaths per day due to war. This is about half the 101 conflict-related deaths per day found in The Lancet study last year, but more than double the 22 deaths per day recorded by the Government of Iraq via its hospital reporting system.

occasional large scale surveys give little more than a glimpse. On-going monitoring of a few sensitive indicators would tell us much more, but no such monitoring existed under the Hussein government, nor was such a system set up under CPA administration.

Conclusion

Security and the economy are the major determinants of Iraq's ill health. Thus, the major challenges to health in Iraq could not have been solved by better use of DFI monies or by constituting a more qualified CPA team. These failures nonetheless left Iraq in worse condition, and with less ability to face to these enormous challenges, than were possible. Mis-utilization of DFI resources and inadequate leadership by the CPA represent enormous lost opportunities in the reconstruction of Iraq.